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Building allied health workforce capacity: a strategic approach to workforce innovation

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Abstract

Objective. The aim of the present study was to identify areas where allied health assistants (AHAs) are not working to their full scope of practice in order to improve the effectiveness of the allied health workforce.

Methods. Qualitative data collected via focus groups identified suitable AHA tasks and a quantitative survey with allied health professionals (AHPs) measured the magnitude of work the current AHP workforce spends undertaking these tasks.

Results. Quantification survey results indicate that Victoria's AHP workforce spends up to 17% of time undertaking tasks that could be delegated to an AHA who has relevant training and adequate supervision. Over half this time is spent on clinical tasks.

Conclusions. The skills of AHAs are not being optimally utilised. Significant opportunity exists to reform the current allied health workforce. Such reform should result in increased capacity of the workforce to meet future demands.

What is known about the topic? Increasing skill shortages across Australia's health workforce necessitates that the capabilities of all healthcare team members should be used optimally. AHA roles are an important and growing response to current health workforce needs. Increasing workforce capacity will ensure the right health workers are matched to the right task by skill, experience and expertise.

What does this paper add? This paper presents a model that assists services to identify tasks suitable for delegation to an AHA by an AHP. The model is unique because it describes a process that quantifies the need for AHAs and it has been successfully implemented in rural, regional and metropolitan health services in Victoria.

What are the implications for practitioners? Working collaboratively, with executive support, will lead to a sustainable and integrated approach to support workforce capacity building. Altering the skill mix of healthcare teams through increasing the role of AHAs has benefits for AHPs, patients and the healthcare system.

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Introduction

Health workforce shortages in Australia have led governments to consider workforce design that optimises human resources to meet the health needs of the population. Australia's aging population and disproportionate levels of chronic disease are likely to result in an even greater reliance on care in a multidisciplinary

context.[1] Developing a health workforce that is configured so that it is fit for purpose with the capability to deliver the right skills in the right place and time at the right cost is essential to overcome challenges of Australia's rapidly changing healthcare system.[2,3]

Building health workforce capacity can be used as an organisational lever to respond to the growing needs of the population, and ensure skills are delivered in the most optimal context. Workforce capacity building has been defined as:

> . . .a continuous and participatory process to empower organisations to systematically identify and respond to institutional needs and the needs of the population it serves, in order to better meet its stated mission and goals, solve problems, implement change and increase efficiency.[4]

Workforce capacity building needs to be incorporated at an individual, organisational and systems level to ensure key components are implemented as intended.[5]

In 2013, the health and social care workforce in Australia was the largest segment of the Australian workforce with over 1.4 million workers,[6] of which 126 000 consisted of allied health professionals (AHPs).[7] 'Allied health' is a broad term that clusters a range of health professions that does not include medicine and nursing.[8] AHPs are university trained and work in a range of settings that include clinical, managerial and policy domains. They are autonomous practitioners who deliver evidence-based practice to clients in order to protect, restore and maintain optimal physical, sensory, psychological, cognitive, social and cultural function.[9]

Allied health assistants (AHAs) are support staff who undertake tasks under the supervision and delegation of an AHP to provide allied health services.[10] AHAs work across a broad range of disciplines, settings and clinical environments, including community, rehabilitation, aged care and mental health.[11] Although increasing evidence supports the benefits of AHAs organisationally,[1,2,5,12] there is limited evidence exploring the relationship between workforce capacity building, the extent to which AHAs are working to their full scope of practice and the effectiveness of the AHA within the health workforce.[13,14] In addition to growing the AHA workforce in traditional settings and disciplines, establishing AHAs in non-traditional settings is a golden opportunity to strategically support clinical service delivery into the future.

The Victorian Department of Health and Human Services (the Department) has undertaken extensive consultation with Victorian allied health staff, unions, professional associations and training providers over the past decade to explore these opportunities. In 2009–11, the Department funded a pilot study to identify and scope potential AHA tasks and quantify the need for AHAs[15] across metropolitan health services. Following the pilot study, a collaborative project team implemented a contextualised AHA methodology across Victorian rural, regional and metropolitan health services, as well as community and ambulatory (non-admitted) services. This broader application of the AHA pilot study methodology, alongside the Supervision and Delegation Framework for Allied Health Assistants,[16] led to the development of the Victorian Assistant Workforce Model (VAWM)–Allied Health. This model reinforces the shared vision outlined in the then Victorian Health Priorities Framework 2012–22[17] to increase allied health workforce capacity. The VAWM was implemented through a three-phase, staged approach (2012–15) across three different geographical locations and clinical settings.

The intention of this paper is to report on the results of focus group and survey data gathered from the VAWM implementation in the first two geographical locations, rural and regional and metropolitan health services. The aims of the VAWM are to: (1) establish a baseline understanding of the current AHP and AHA workforce in Victoria and identify staff profile data; (2) identify AHA potential tasks and determine fit with the current scope of practice for both multidisciplinary and single disciplinary roles; (3) quantify the time spent by AHPs in the identified AHA attributable tasks; and (4) provide support to local organisations to develop a strategic plan that builds sustainable AHA workforce capacity. At the time of writing, the model was being implemented in metropolitan community and ambulatory services and therefore will not be reported in this paper.

Methods

The VAWM is based on a mixed-method approach to build the evidence base of a replicable but flexible model that guides health workforce capacity building. It is customised for different contexts, and provides a framework for planning, collecting information, making decisions and improving the scope of practice of the AHA workforce. The model provides a structure to identify AHA need, quantify this need and strategically plan for future workforce redesign to incorporate increased AHAs in the allied health workforce. A successful long-term outcome of VAWM implementation will be that the allied health workforce is fit for purpose with the right worker completing the right tasks, within the appropriate scope of practice. Figure 1 illustrates the elements and phases integrated in the model.

Participants and setting

Victorian public health and community services (including tertiary hospitals) were invited to participate in the VAWM implementation via an open expression of interest process. VAWM participants included AHPs and AHAs working across these organisations. Participation in the program was voluntary and information statements were provided with consent implied through participation. Participants from Stage 1 (S1) were clustered into 16 subregional clusters of two to eight separate services or organisations from rural and regional Victoria. These consisted of hospitals, community services, home and community care, mental health, aged care services, Aboriginal Community Controlled Organisations, local government and private providers. Participants from Stage 2 (S2) were from 12 metropolitan health services incorporating acute and subacute bed-based services, allied health out-patient services, palliative care, transition care programs, in-patient mental health services and a maternity collaborative at two tertiary hospitals. For the purposes of this paper, all health services and clusters will be referred to as participating organisations. The VAWM received

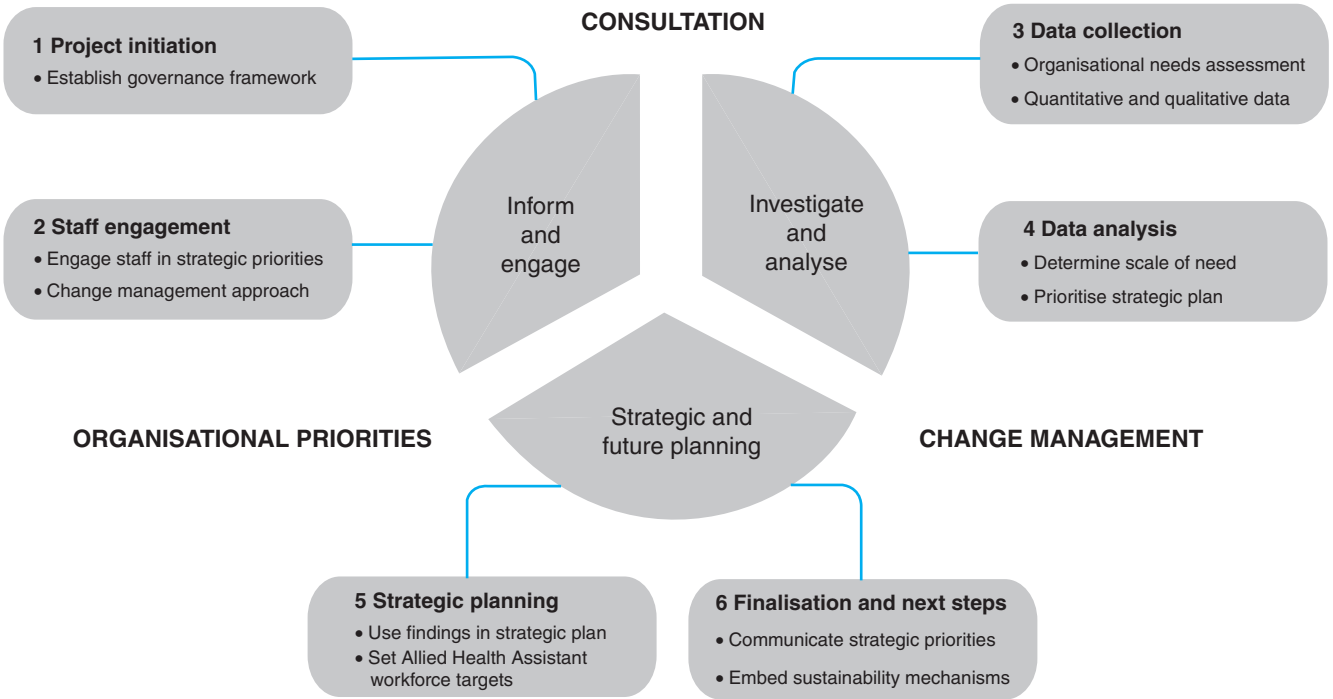

Fig. 1. Victorian Assistant Workforce Model–Allied Health. AHA, allied health assistant.

ethics approval from the Alfred Health human research ethics committee.

Model implementation

Baseline data were collected through a workforce survey sent out to all AHA and AHP staff employed across participating organisations. The workforce survey included themes, with specific questions contextualised to either the AHP or AHA workforce. Data collected included organisational demographics (classification, discipline and duration of employment), job satisfaction, information relating to AHA roles, AHP attitudes towards current utilisation of the assistant workforce, AHP confidence in delegating tasks to AHAs and perceived barriers to AHA workforce growth and factors that may affect recruitment and retention.

To determine AHA potential tasks and fit with the current scope of practice, focus groups were conducted. Qualitative data collected from focus group discussion identified and verified the potential tasks suitable and the future scope of practice for AHAs. The task data collected were classified into 10 broad practice categories informed by the pilot study,[15] as follows: clinical categories of assessment, treatment, complex cases, clinical reporting, discharge planning, equipment and environment; and non-clinical categories of research and quality, supervision, administration and 'other'. Additional interviews with key stakeholders and allied health discipline managers ratified the discipline or service tasks that were assigned to the practice categories at local participating organisations (see Appendix 1 for examples of treatment tasks suitable for delegation to an AHA).

A quantification survey was disseminated to quantify the time spent by AHPs in an AHA-attributable tasks. A paper-based quantification survey was disseminated to AHPs working within participating organisations across S1 and S2. The survey informed focus group findings and listed the tasks and practice domains identified and ratified previously. The AHPs were required to record how many minutes they performed AHA work each day for a week and recorded work tasks during this time that could be effectively delegated to an AHA. Staffing profile data (work force composition, full-time equivalent (FTE) and vacancies), collected before the survey, were used to determine the percentage of AHP time that could be delegated to AHAs as well as the response rate to the quantification survey.

To facilitate sustainability, organisations were guided to develop local strategic plans that integrated the findings from qualitative and quantitative data collection, together with local organisational priorities. This would establish sustainable and achievable workforce goals relating to capacity building of the AHA workforce.

Results

In all, 83 health service organisations across 120 sites in Victoria participated in the VAWM implementation. In S1, there were 71 rural and regional organisations across 86 sites, and in S2 there were 12 metropolitan health services across 34 sites. Participants totalled 3053 allied health workers, including 2703 AHPs and 350 AHAs. There was considerable variability in the composition of the AHA workforce across both stages due to location. Rural and regional AHAs comprised between 2% and 23% of the allied health workforce in S1, compared with 0%–11% of AHA staff in the metropolitan health workforce across S2 (Table 1).

In all, 69% (n = 783) of S1 allied health participants and 88% (n = 1666) S2 allied health participants responded to the online VAWM staff workforce survey. The surveys were a tool for

participating organisations to provide insight into the current status of the organisation's allied health workforce (Table 2). Both AHA and AHP job satisfaction and stimulating workloads were rated satisfying or highly satisfying (84.5%–90%). Conversely, AHA access and delegation of AHP workloads were rated somewhat lower (55.5%–61%). Of the AHP participants who completed the survey, 47% held a Grade 2 qualification and 27% held senior staff positions with a Grade 3–5 qualification. Physiotherapists (26%) and occupational therapists (22%) were the disciplines most highly represented in survey responses.

Further opportunity for AHA workforce growth was highlighted in the AHP survey, with 55.5% of AHPs reporting that they currently completed clinical tasks that could be delegated to an AHA. AHPs reported a high level of confidence in the clinical skills (85%) and utilisation of the current AHA workforce by the AHP profession (83.5%), as well as confidence in delegating tasks to AHAs (84.5%).

A total of 1162 allied health participants contributed to focus group discussions. Focus groups consisted of 380 staff in S1 and 782 staff in S2. A key outcome of focus group feedback was AHP identification of tasks suitable to be delegated to AHAs. The quantification survey identified 14 792 h (6259 h in S1 and 8533 h in S2) could be delegated to an AHA who has relevant training and adequate supervision. This represented 11% of current AHP time in S1 and 17% of current AHP time in S2 that could be delegated to an AHA. Clinical tasks represented the majority of work that could be delegated to an AHA in both S1 and S2 (Fig. 2); on average, 73% of identified AHA-attributable task work was clinical and 27% was non-clinical. The average clinical component of the AHA role included: 10% assessment with feedback from an AHP; 30% treatment; 4% complex cases; 8% clinical reporting; 9% discharge planning; and 12% equipment and

Table 1. Allied health workforce baseline data 2012–13
AHP, allied health professional; AHA, allied health assistant

Baseline	Stage 1	Stage 2	Total
No. organisations	71	12	83
No. site	86	34	120
Physical no. staff			
AHP	920	1783	2703
AHA	177	173	350
Total no. staff	1097	1956	3053
Full-time equivalent			
AHP	934	1326	2260
AHA	131	120	251
Total full-time equivalent	1065	1446	2511
% AHA staff in allied health (stage commencement)	12.29%	8.26%	10.27% (average of S1 and S2)

Table 2. Allied health staff workforce survey 2012–13
AHP, allied health professional; AHA, allied health assistant

	Stage 1 and Stage 2 average
AHAs reporting job satisfaction as satisfying or highly satisfying	90%
AHA learning needs are being met	88%
AHPs reporting job satisfaction as satisfying or highly satisfying	91.5%
AHPs reporting AHAs are employed in their organisation	89.5%
AHP work role as stimulating or highly stimulating	84.5%
AHPs reporting access to AHAs to support their work	61%
AHPs report additional tasks exist for AHAs within their current workload	55.5%
AHP work role as dissatisfying or highly dissatisfying	8.5%
AHPs reporting utilisation of AHAs in daily workload as not applicable	7.5%

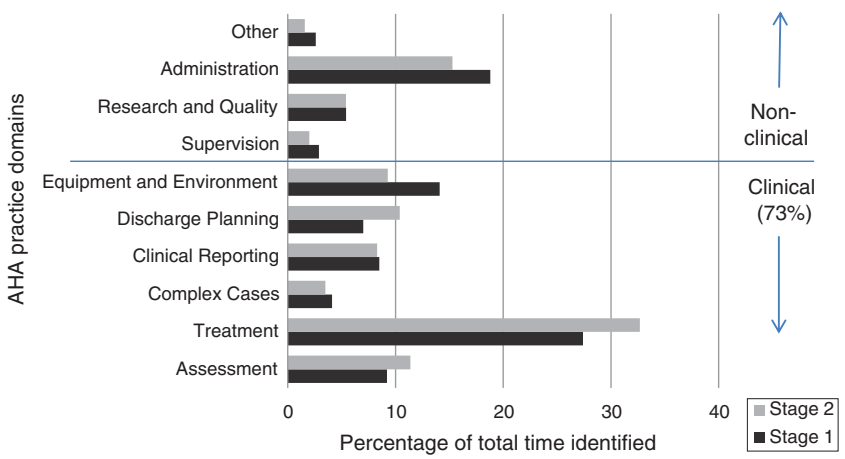

Fig. 2. Percentage breakdown of allied health assistant (AHA) practice domains identified by AHPs during the quantification surveys.

environment. Non-clinical AHA work included 5% research and quality, 3% supervision, 17% administration and 2% other.

Within these clinical tasks, those related to the delivery of treatment were the most common, with 2793 h (73.5 FTE) identified in S1 and 1718 h (45.2 FTE) identified in S2. This was common at a discipline level to all disciplines in S1 except in dietetics and social work. The largest proportion of time identified in these disciplines was administration (26% of time identified). In both these disciplines, treatment tasks were the next highest category. Compared with S2, audiology identified the largest proportion of time in the administration category (40% of time identified) and psychology the largest proportion of time in the research and quality category (19% of time identified). In all other disciplines, most of the time identified was in treatment tasks.

From a service perspective, outreach services recorded the greatest proportion of AHA time (63%) in S1. In contrast, acute in-patient service in S2 identified the greatest proportion of AHA time (42.5%). In S2, an optional data-reporting field, (speciality clinical program), was included. Of the surveys returned, 25% recorded data against this field. Across speciality clinical programs, 50 FTE was identified. The largest FTE was identified in general rehabilitation units (13.6 FTE) in subacute services. Of the time identified, the largest number of hours was in the treatment category (27%), followed by administration (18%).

Podiatry, followed by speech pathology and exercise physiology, recorded the highest percentage of AHA-attributable time that could be delegated to appropriately qualified and supervised AHAs (Fig. 3). In both stages, clinical incident data were reviewed. No incidents were identified in either S1 or S2 that involved AHAs. One hundred per cent of the 83 rural, regional and metropolitan health services participating in the VAWM implementation committed to developing a strategic plan for integrating the AHA workforce.

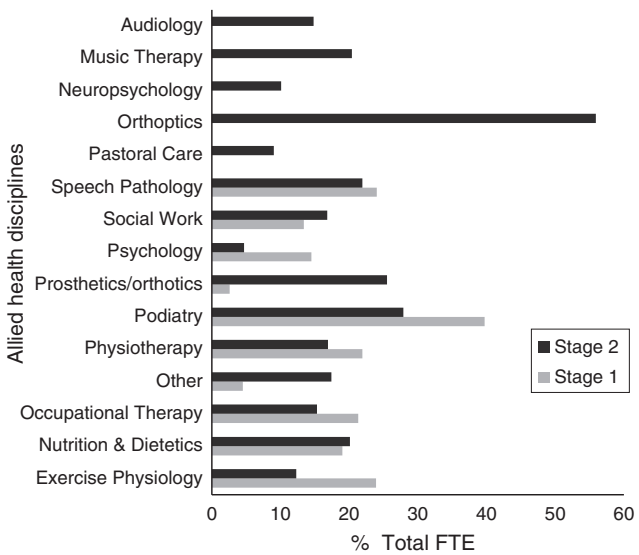

Fig. 3. Allied health assistant time identified as a percentage of total full-time equivalent (FTE) against the budgeted FTE for each discipline.

Discussion

The scale of AHP tasks suitable to be delegated to AHAs (11%–17%) indicates that reallocation of tasks and reprioritisation of AHP workload would have cost benefits and significant productivity gains.[7,18] This could translate to increased occasions of service and therapy intensity resulting in improved patient outcomes in all health settings. It is likely that the rural and regional allied health workforce, by necessity in filling vacant AHP positions, has been pursuing workforce reform earlier than metropolitan colleagues and hence is already demonstrating higher proportions of AHA workforce and lower indication of AHA need. Despite this, a need still exists.

The quantification of the AHA-attributable work is a unique component of the VAWM. Incorporating focus groups with AHP staff from a variety of disciplines and services enabled those AHPs who were familiar with AHA practice and were very satisfied with the level of utilisation, support and delegating tasks to AHAs to influence other AHPs less familiar or comfortable with the AHA workforce. This positively stimulated discussion in the focus groups, identifying more tasks that could be delegated to AHAs than what has appeared in the literature to date.

An integral part of the VAWM was fostering capacity building at the organisational level, which is more likely to facilitate sustainable workforce change. This included leadership through mentoring, encouraging partnerships, networking, challenging existing culture and information and resource sharing.[19] Some organisations have progressed partnerships with registered training organisations to provide local learning packages for their AHA staff. Other developments have included the establishment of a statewide AHA workforce reference group to support ongoing information and resource sharing.

Interestingly, the key themes identified in the strategic plans in S1 and S2 are very similar. These included the introduction of new AHA roles, implementation of AHA workforce governance frameworks including credentialling and a scope of practice guide, development of local AHA competencies, creation of AHA position descriptions for new and/or amended roles, formalising supervision and delegation models and providing professional development opportunities for AHAs. A commonality of recurring themes in strategic planning suggests that even though an AHA workforce may exist within an organisation, there is still ongoing work that is necessary to formalise and ratify organisational practice. This may be due to the ad hoc historical evolution of the assistant workforce in healthcare.

This VAWM is not about substitution of AHP roles with AHA roles, but rather matching the right task to the right worker. A concern frequently expressed by AHPs was the replacement of professional roles. Refocusing AHPs' discussion to what their job would be like if they were working at the higher end of practice scope created an understanding of the need for workforce reform and excitement for the future. Ensuring AHP support and understanding of the AHA role is another essential component in order to achieve an integrated allied health workforce.

The support provided by AHAs may release AHPs to undertake a greater amount of high-level tasks required for patients with complex needs, longer AHP treatment time and enhanced access of services to clients.[9] This has enabled greater opportunity

to expand the use of AHAs in multidisciplinary healthcare teams delivering new and innovative models of care in response to community need.[11] A limitation of the current pilot study was that the time demands of supervision and training of AHA staff was not factored into the quantitative survey. It may not always be efficient to delegate tasks to a support workforce if this requires large amounts of time dedicated to supervision and delegation of the tasks. In order to have an effective AHA workforce, supporting educational and competency frameworks must be established to support learning and development in this workforce. The measurement of productivity and quality gains related to reallocation of tasks is an opportunity for future research.

For AHPs to evolve to meet future demands, it is necessary to reallocate lower-level tasks to a support workforce in order to create capacity to concentrate on complex tasks only an AHP can do. Qualitative data indicated that nearly half (55.5%) of AHPs withheld delegation of clinical tasks to assistants. Although this issue has been generally reported in assistant workforce literature, it is useful for organisations to understand what factors create an AHP's readiness to delegate. The focus group discussions confirmed this can be related to: (1) AHA's familiarity with the task; (2) the quality of the relationship with the assistant; (3) their confidence in the assistant; and (4) their belief about whether the task was appropriate to be delegated to an assistant. As noted in the literature, optimisation of assistants can be achieved when the process is based on skills and confidence instead of relying on established relationships.[10] Clearly, it is important for all assistants to achieve appropriate levels of competency. It is also equally important that AHPs have adequate understanding of the importance of delegating, skills in delegation and confidence in the structures of delegation.

Conclusion

Workforce capacity building is an important organisational lever to ensure health workforce skills are delivered in the most optimal context. Quantifying the time spent by AHPs in an AHA-attributable task is a unique feature of the VAWM to develop a health workforce that is configured so that it is fit for purpose, with the capability to deliver the right skills in the right place and time at the right cost. This is essential in order to overcome the challenges of Australia's rapidly changing healthcare system. Organisational demographics, job satisfaction, current AHA roles, AHP confidence in delegating tasks to AHAs and perceived barriers to AHA workforce growth are further components that organisations should take into account to create workforce capacity building success. Integrating the AHA role from a systems, organisational and individual level is key to create allied health workforce sustainability. The implementation phase of S1 and S2 demonstrates that the VAWM is a successful framework that can assist healthcare organisations to strategically align their allied health workforce now and into the future.

Competing interests

None declared.

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Appendix 1. Tasks suitable for delegation by an allied health professional (AHP) to allied health assistant (AHA), Victorian Assistant Workforce Model–Allied Health

Treatment category	Examples
Refer clients to community programs, groups or services under guidance from the AHP	
Administer prescribed therapy	Exercise programs, gym sessions, hydrotherapy, scooter training, upper limb range of motion, hand therapy, personal care retraining, upper limb retraining, education of making thickened fluids and texture-modified diets, functional therapy, cooking sessions, meal preparation practice, meal set up and retraining
Assist with formatting and presentation of client education material	Exercise sheets, gait aid education information
Fill, prepare plaster impressions and casts	
Fit and review basic orthoses	Slings, cast shoes and/or postoperative shoes
Lead or co-facilitate group programs	Supermarket tours, communal dining group, strength and balance, falls prevention, lunch group, relaxation groups
Nail care, assist with selection of footwear	
Prepare therapy materials	
Assist AHP with treatment, practical assistance with clients, including hearing aids cleaning, battery changing	
Distribution of amplification devices such as ‘easy listener’	
Standardised education for client use of equipment	
Assist AHP with manual handling tasks	
Provide and reinforce prescribed education	
Prepare therapy materials such as splinting	
Assist with paperwork relevant to client, such as community referrals	
Recruit appropriate patients for exercise class	
Assist with recreation visits under the guidance of the AHP	
Assist in pastoral care	